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Advancement of women

Supporting efforts to end obstetric fistula

Report of the Secretary-General

Summary

The present report was prepared in response to General Assembly resolution 62/138. Obstetric fistula is a devastating childbirth injury that leaves women incontinent and often isolated from their communities. It is a stark example of continued poor maternal and reproductive health services and an indication of high levels of maternal death and disability. The report outlines efforts to end obstetric fistula at international, regional and national levels, including by the United Nations system. It concludes with recommendations to intensify efforts to end obstetric fistula as part of support to the achievement of Millennium Development Goal 5, including strengthening health systems and increasing levels and predictability of funding.

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I. Introduction

1. The present report is submitted in accordance with General Assembly resolution 62/138 in which the Assembly requested the Secretary-General to submit a report at its sixty-third session on the implementation of the resolution. This report outlines the main causes of obstetric fistula and efforts by the international community and the United Nations system to address it, as well as recommendations for consideration by the General Assembly. As requested in the resolution, the report is presented under the agenda item entitled "Advancement of women".

II. Background

2. Obstetric fistula is a devastating childbirth injury that leaves women incontinent, ashamed and often isolated from their communities. It is a stark example of poor maternal and reproductive health and an indication of unacceptably high levels of maternal death and disability. It disproportionately affects impoverished women and girls living in rural communities in developing countries. Obstetric fistula is almost entirely preventable through access to quality maternal health care. The same interventions will prevent maternal death and other disabilities. Surgery can mend the injury, and with care to address the social consequences, most women who have lived with fistula can resume full and productive lives. Bringing an end to obstetric fistula requires addressing underlying social and economic inequities that hinder women from fulfilling their reproductive rights, including choosing when to marry and have children, accessing education and reproductive health services, and preventing child marriage and early childbearing.

3. Prolonged, obstructed labour causes the vast majority of obstetric fistulas worldwide. Globally, obstructed labour occurs in nearly 5 per cent of deliveries. When a woman with prolonged, obstructed labour does not receive timely medical care, typically a Caesarean section, the pressure of the baby's head against the woman's pelvis can cause extensive damage. If the woman survives, she may be left with a hole — an obstetric fistula — leaving her continuously leaking urine and/or faeces. Women living with obstetric fistula have typically survived three days of labour and some longer than a week. In as many as 90 per cent of cases, the baby is stillborn or dies within the first week of life.[1]

4. Women living with obstetric fistula experience both medical and social consequences. In addition to leaking urine, women may experience bladder infections, painful sores, kidney failure and infertility. The smell from the constant leaking combined with misperceptions about its cause often results in stigma and ostracism by communities. Many women are abandoned by their husbands and in some cases by their families. They often cannot participate in daily family and community life, such as attending social events, practising their religion or assisting with household tasks. They may find it difficult to maintain a source of income or support, thereby deepening their poverty. Feelings of isolation may affect their mental health, resulting in depression, low self-esteem and in some cases suicide.

[1] L. L. Wall, J. A. Karshima, C. Kirschner and S. D. Arrowsmith, "The obstetric vesicovaginal fistula: characteristics of 899 patients from Jos, Nigeria", *American Journal of Obstetrics and Gynecology*, vol. 190, No. 4 (April 2004), pp. 1011-1019.

5. While robust population-based measurements are lacking, it is generally accepted that at least 2 million women, and as many as 3.5 million, are suffering from obstetric fistula.[2] The World Health Organization (WHO) estimates that approximately 73,000 new cases occur annually,[3] which may be an underestimate as it is based on facility data and the majority likely never reach a hospital. Obstetric fistula occurs most often in areas where maternal mortality is high, such as sub-Saharan Africa and South Asia where the majority of the annual 500,000 maternal deaths occur and maternal mortality ratios often exceed 300 per 100,000 live births.[4] The lifetime risk of maternal death in these regions can be 1,000 times greater than in industrialized regions, representing the greatest health inequity in the world. In regions such as Latin America and the Caribbean and the Arab States, great progress has been made, but some countries and certain populations continue to experience high rates of maternal death. Countries affected by humanitarian emergencies have some of the highest rates.

6. Optimal maternal health, including elimination of obstetric fistula, will ultimately be achieved through universal access to reproductive health. The current situation reflects weak health systems, including inadequate human resources, and lack of access to reproductive health services. Within reproductive health, three interventions will have the most immediate impact on maternal death and disability: family planning, attendance during childbirth by skilled health personnel and emergency obstetric care in the case of complications:

- Family planning can assist in preventing pregnancies among adolescents and reducing the number of pregnancies and therefore exposure to the risk of death or disability. Globally, 37 countries have an unmet need for family planning greater than 20 per cent among married women and 24 countries have a contraceptive prevalence rate for modern methods of less than 10 per cent.[5]

- Less than half of women in Asia and Africa are assisted during delivery by skilled health personnel.[6] Socio-economic disparities are great; for instance, skilled care is 34 percentage points higher for women in the highest socio-economic quintiles than for those in the lowest in the 68 countries accounting for most maternal deaths.[7] The human resource crisis in the health sector contributes to this challenge with WHO estimating that at least 300,000 midwives are required to fill the gaps.[8]

- Emergency obstetric care encompasses medical interventions that can prevent complications from becoming fatal or causing disability such as obstetric

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[2] L. L. Wall, "Obstetric vesicovaginal fistula as an international public-health problem", *The Lancet*, vol. 368, Issue 9542 (30 September 2006), pp. 1201-1209.

[3] C. AbouZahr, "Global burden of maternal death and disability", *British Medical Bulletin*, vol. 67, No. 1 (December 2003).

[4] *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank* (Geneva: World Health Organization, 2007).

[5] United Nations Population Fund and the United Nations Population Division, 2008.

[6] World Health Organization, Proportion of births attended by a skilled health worker: 2008 updates.

[7] Countdown 2008 Equity Analysis Group, "Mind the gap: equity and trends in coverage of maternal, newborn and child health services in 54 Countdown countries", *The Lancet*, vol. 371, Issue 9620 (12 April 2008), pp. 1259-1267.

[8] World Health Organization, *The World Health Report 2005: Make Every Mother and Child Count*, (Geneva: 2005).

fistula. The United Nations recommends five facilities offering emergency obstetric care per 500,000 population with at least one providing comprehensive care.[9] Yet, national assessments show that even basic services are often unavailable.[10] Caesarean section, key for preventing obstetric fistula, remains well below the recommended 5 to 15 per cent for the poorest women in countries with high maternal mortality.[11]

7. The persistence of obstetric fistula reflects not only health system constraints, but also the broader economic and sociocultural context. Poverty and gender inequality impede women's opportunities, including access to services. Cultural preferences for unassisted home delivery inhibit utilization of services. The cost of health care can be financially catastrophic for poor families. In addition, the deficiencies of other infrastructure, such as transport and communications, further compound the difficulties of access. These factors impact on the three delays that impede women's arrival to health care: the delay in seeking care, in arriving at a health facility, and in receiving care at the facility.

8. First-time births carry the greatest risk of obstetric fistula and require closer monitoring.[12] Due to declining fertility and decreases in number of births, a rising proportion of all births will be first births, with their special needs. Establishing positive habits among first-time mothers and their partners regarding delivery, infant feeding and birth spacing choices are also likely to shape lifelong behaviours.

9. Adolescent girls are particularly at risk for obstetric fistula and face two to five times greater risk of maternal death compared to women in their twenties. There is evidence that delaying pregnancy until after adolescence may reduce the risk of obstructed labour, and therefore obstetric fistula.[13] The average number of births among girls aged 15 to 19 in developing countries is more than five times greater than for girls from developed countries.[14] Often with few resources and little knowledge about reproductive health, 14 million adolescent girls give birth each year.[15] Malnutrition among girls may stunt pelvic growth and early pregnancies before the pelvis is fully developed can contribute to increased risk of obstructed labour.[16] Adolescent girls are also more likely to give birth without a skilled

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[9] United Nations Children's Fund, World Health Organization and United Nations Population Fund, *Guidelines for Monitoring the Availability and Use of Obstetric Services*, (New York: UNICEF, 1997).

[10] A. Paxton, P. Bailey, S. Lobis and D. Fry, "Global patterns in availability of emergency obstetric care", *International Journal of Gynecology & Obstetrics*, vol. 93, No. 3 (June 2006), pp. 300-307.

[11] C. Ronsmans, S. Holtz and C. Stanton, "Socioeconomic differentials in caesarean rates in developing countries: a retrospective analysis", *The Lancet*, vol. 368, Issue 9546 (28 October 2006), pp. 1516-1523.

[12] J. Kelly and B. E. Kwast, "Epidemiologic study of vesicovaginal fistulas in Ethiopia", *International Urogynaecology Journal*, vol. 4, No. 5 (October 1993), pp. 278-281.

[13] A. O. Tsui, A. A. Creanga and S. Ahmed, "The role of delayed childbearing in the prevention of obstetric fistulas", *International Journal of Gynecology & Obstetrics*, vol. 99, Supplement 1 (November 2007), pp. S98-S107.

[14] Guttmacher Institute, *U.S. Teenage Pregnancy Statistics: National and State Trends and Trends by Race and Ethnicity*, (New York: Guttmacher Institute, 2006).

[15] United Nations Population Fund, 2007. Giving Girls Today and Tomorrow.

[16] J. P. Neilson, T. Lavender, S. Quenby and S. Wray, "Obstructed labour. reducing maternal death and disability during pregnancy", *British Medical Bulletin*, vol. 67, No. 1 (December 2003), pp. 191-204.

attendant. A woman who begins childbearing at a young age usually has more children and at shorter intervals, which is linked to higher risk for maternal death or disability.

10. Additionally, socio-economic factors also contribute to early pregnancy and childbearing, heightening the risk of obstetric fistula. Evidence demonstrates that poor, marginalized girls are more likely to marry and give birth during adolescence than girls with greater economic and educational opportunities. Girls are often expected to have children immediately after marriage, and given their low status within households, others may make decisions about their health and use of services. Child marriage is a violation of the Convention on the Rights of the Child and illegal in many countries. Age at first marriage is rising; however, more than 100 million girls in developing countries will be married before the age of 18 in the next decade.[17]

11. For women living with obstetric fistula, treatment can heal the fistula in 85 to 90 per cent of cases. Few health facilities are able to provide fistula treatment due to the limited number of health professionals with appropriate skills. In addition, staff, equipment and space shortages are common.[18] Many women are not aware, cannot afford or cannot reach services even when available. It has been estimated that approximately 7,000 women are treated annually — just 10 per cent of new cases and barely touching the backlog of 2 million women or more. Owing to the social and psychological consequences, women also need support to rebuild self-esteem and to reintegrate into society. This support may include counselling services, literacy and vocational training, and health education.

12. In 2003, the United Nations Population Fund (UNFPA) and partners launched the global Campaign to End Fistula with the goal of eliminating obstetric fistula by 2015, by preventing and treating obstetric fistula and empowering women to return to society after treatment. The Campaign is now active in more than 45 countries in Africa, Asia and the Arab States. An international partnership, the Obstetric Fistula Working Group, was created in 2003 with the purpose of ensuring global coordination of efforts to eliminate obstetric fistula. The Campaign aims to contribute to Millennium Development Goal 5 to improve maternal health and goal 3 to promote gender equality and empower women.

III. Efforts at intergovernmental and regional levels

A. Intergovernmental actions

13. For two decades, the United Nations and the international community have campaigned to reduce maternal mortality and morbidity. Global commitments were first made at the 1987 International Safe Motherhood Conference in Nairobi. At the 1994 International Conference on Population and Development in Cairo, maternal health was recognized as a key component of sexual and reproductive health. At the

[17] United Nations Population Fund, *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy*, 2007.

[18] A. Velez, K. Ramsey and K. Tell, "The Campaign to End Fistula: What have we learned? Findings of facility and community needs assessments", *International Journal of Gynecology & Obstetrics*; vol. 99, Supplement 1 (November 2007), pp. S143-S150.

Fourth World Conference on Women, in Beijing (1995), Governments recognized that entrenched patterns of social and cultural discrimination are major contributors to sexual and reproductive ill-health, including maternal death and disability, along with lack of information and services. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women requires States to ensure that women have appropriate services in connection with pregnancy, confinement and the post-natal period. Article 24 of the Convention on the Rights of the Child also requires that States take adequate measures to ensure appropriate prenatal and post-natal health care for mothers.

14. In 2000, world leaders reaffirmed commitments to improve maternal health through Millennium Development Goal 5, setting a target to reduce the maternal mortality ratio by 75 per cent by 2015 (see A/56/326). The same interventions that will reduce mortality will also prevent morbidities such as obstetric fistula. The addition of the target of universal access to reproductive health under goal 5 subsequently ensured full coverage of all the factors for improving maternal health. The other Millennium Development Goals, in particular goal 3, goal 4 and goal 6, are closely related to women's health and survival. Currently, progress on goal 5 lags behind all the other goals and has the lowest level of financial support. No region has achieved sufficient annual maternal mortality declines to reach the target. Of the 68 countries that account for most maternal and child deaths, only 16 per cent are on track to reach goals 4 and 5 by 2015.

15. The General Assembly recognized the problem of obstetric fistula in its resolution 60/141 on the girl child, in which the Assembly urged States to promote gender equality and equal access to basic services such as education, nutrition and health care, including sexual and reproductive health. It recognized the role of early childbearing and limited access to sexual and reproductive health as key factors in the persistence of obstetric fistula, maternal mortality and other morbidities.

16. The Special Rapporteur on the right to the highest attainable standard of physical and mental health examined the relationship between the right to health and the reduction of maternal mortality. The report (A/61/338), submitted to the General Assembly in 2006, emphasized that the right to health entitles women to the continuum of maternal health services. It also pointed out that the right to health encompasses entitlements to social, economic, cultural and political determinants of health and called for a human rights campaign against maternal mortality.

17. In 2007, the Secretary-General's report submitted pursuant to resolution 60/141 (A/62/297), noted efforts by the Committee on the Rights of the Child to highlight the continued discrimination against girl children, particularly marginalized girls. The report also focused on child marriages and early pregnancies, noting that in many countries the minimum age of marriage is not established and/or enforced. A special section was dedicated to efforts to end obstetric fistula. The report provided updates on the global Campaign to End Fistula, led by UNFPA in partnership with Member States, United Nations agencies and other organizations.

18. The Commission on the Status of Women in 2007 focused on strategies for the elimination of all forms of discrimination and violence against the girl child. The

adopted agreed conclusions,[19] among other things, urged Governments to take necessary measures to ensure the rights of the girl child in areas such as education and health, including quality reproductive health information and services. They also recognized the higher risk of obstetric fistula and maternal death among adolescents.

19. The October 2007 Women Deliver conference held in London brought nearly 2,000 participants from 109 countries together to mobilize political and financial support for women's health, particularly to prevent maternal death and disability. Expert participants demonstrated that investing in women is an essential element of development. It was the first global forum at which women who had lived with obstetric fistula had the opportunity to speak publicly about their experiences. The conference closed with a pledge by 70 Cabinet ministers and parliamentarians to make the achievement of goal 5 a high priority on the national, regional and international agendas.

20. General Assembly resolution 62/138, entitled "Supporting efforts to eliminate obstetric fistula", with 138 Member States as co-sponsors, was adopted in December 2007. In the resolution the Assembly stressed the interlinkages between poverty, malnutrition, inadequate or inaccessible health services, early childbearing and child marriage as the main causes of obstetric fistula. It also stressed the obligation of States to promote and protect all human rights and fundamental freedoms of women and girls. It further invited States to contribute to efforts to end obstetric fistula, including the UNFPA-led global Campaign to End Fistula.

B. Regional actions

21. Concerned about the lack of progress on goals 4 and 5, the African Regional Reproductive Health Task Force in 2003 called on African countries to develop a road map for accelerated maternal and newborn mortality reduction. The plan, endorsed by WHO, UNFPA, the United Nations Children's Fund (UNICEF), the World Bank and other task force members, aims to help Governments plan and mobilize support for skilled attendance during pregnancy, childbirth and the post-natal period, at all levels of the health system, and strengthen the capacity of individuals, families and communities to improve maternal and newborn health. To date, over 40 African countries have developed road maps.

22. In 2005, Governments and technical partners convened in Johannesburg, South Africa, to develop the Call to Action to Make Motherhood Safer by Addressing Obstetric Fistula. Participants at the meeting, convened by the Government of South Africa, UNFPA and WHO, urged African Governments to ensure the implementation and scale-up of national programmes to address obstetric fistula and improve maternal health. It was recommended that States and civil society should work together to address gender equality and girls' education and to strengthen health systems by adopting a broad multisectoral approach. A strategy for the African Region to eliminate obstetric fistula was developed.

23. In 2006, African health ministers assembled in Maputo to develop a common plan of action for the reproductive health and rights framework endorsed by the

[19] See *Official Records of the Economic and Social Council, 2007, Supplement No. 7* (E/2007/27-E/CN.6/2007/9), chap. I, sect. A.

African Union in January 2006. Reducing maternal mortality and morbidity, including ending obstetric fistula, constitutes a key component of the framework. The Maputo Plan of Action responds to various vulnerabilities, including gender inequality, rural living and youth, and the specific vulnerability of migrants, refugees and displaced persons. Countries in the region are now translating these commitments into national plans and actions.

24. In Asia, the South Asian Association for Regional Cooperation (SAARC) under its 2005-2010 Development Goals incorporated maternal health focusing on reducing maternal mortality and improved nutritional standards for adolescent girls and pregnant women. Key targets include increased skilled birth attendance, pre- and post-natal care and a rapid decline in total fertility rates. SAARC also plans to develop a concept paper on maternal health for the 2009 inter-ministerial summit that will cover priority countries for reducing maternal mortality and morbidity: Afghanistan, Bhutan, India, Nepal and Pakistan.

25. In addition, a Regional Network for Maternal and Neonatal Mortality and Morbidity Reduction is active in South Asia. Members of the Network include the United Nations system, non-governmental organizations, professional associations, regional development banks and SAARC. The Network has identified as priorities the strengthening of health systems focusing on the health workforce, improving the quality of services, scaling up the number of community midwives, and demand creation linked to efforts to improve service affordability. Collective action is focused on advocating for skilled human resources for maternal and newborn health. The Network met in June 2008 to review countries' situations, share experiences and plan approaches to strengthen the workforce.

26. A Regional Inter-agency Task Force for the Reduction of Maternal Mortality was established almost a decade ago in the Latin America and the Caribbean Region to address regional challenges to maternal mortality and morbidity reduction. Members include United Nations agencies, bilateral donor agencies, development banks and non-governmental organizations. The Task Force meets regularly and is guided by an inter-agency strategic consensus developed in 2002. Current priorities include mobilizing political commitment, collecting and analysing data to demonstrate the problem and to identify the most affected populations, and capacity development in strengthening health systems.

IV. Recent actions taken by Member States and the United Nations

A. Data collection and analysis

27. A series on maternal survival in *The Lancet* in 2006 analysed the evidence accumulated over the last 20 years on reducing maternal mortality and morbidity, presenting the most effective interventions based on this evidence. This analysis has assisted in building consensus and a focus on ways to scale up interventions and to strengthen monitoring systems to track trends in maternal deaths and accessibility of maternal health services.[20]

[20] V. Filippi, C. Ronsmans, O. Campbell et al., "Maternal health in poor countries: the broader context and a call for action", *The Lancet*, vol. 368, Issue 9546 (28 October 2006), pp. 1535-1541.

28. Efforts are under way to improve monitoring of progress towards the goal 5 targets, including measurement of both maternal mortality reduction and universal access to reproductive health. In this vein, WHO and UNFPA have proposed priority indicators for national-level monitoring.[21] Among the indicators, there is a subset related to maternal and perinatal health, including obstetric fistula.

29. The 2005 maternal mortality estimates produced by WHO, UNICEF, UNFPA and the World Bank provide an indication of progress towards goal 5.[22] The trend analysis between 1990 and 2005 shows that maternal mortality ratios globally decreased by less than 1 per cent annually, far short of the rate needed to achieve goal 5. The data also highlight the vast inequities between developing and developed countries, with sub-Saharan Africa and South Asia accounting for 86 per cent of maternal deaths in 2005. Similarly, lifetime risk of maternal death[23] ranges from 1 in 7 in Niger to 1 in 7,300 in developed countries.

30. A 2003 needs assessment of nine African countries, by UNFPA and Engender Health, provided one of the first multi-country data sources on obstetric fistula. With support from UNFPA and others, 36 countries have now conducted assessments, documenting baseline information on the problem and its sociocultural dimensions. Poverty was frequently cited as the main underlying cause because of its connection with lack of access to health care, malnutrition, child marriage and early childbearing.[24] Women were prevented from accessing maternal health services due to refusal by relatives, long distances and lack of transport, high costs, and poor quality of services. Existing capacity to treat fistula was found in most countries, as well as challenges due to health worker shortages, inadequate equipment, supplies and facility space, and lack of subsidized care for poor patients. The data and national dissemination have helped to raise awareness about obstetric fistula and to design programmes.

31. Many assessments identified limitations of national data on maternal health, specifically obstetric fistula. Similar challenges were identified in assessments of emergency obstetric care conducted in 32 countries. Data are often not routinely collected through health information systems, hampering analysis of progress. There are efforts in several countries, such as Nigeria and Uganda, to develop national databases on obstetric fistula. Malawi, Morocco, Bangladesh, Nepal and Pakistan have integrated some or all of the indicators for emergency obstetric care recommended by the United Nations[25] in health information systems. The Obstetric Fistula Working Group is working on a report with recommendations for obstetric fistula-related indicators which will be finalized by the end of 2008.

32. Owing to the need for population-level data, the Democratic Republic of the Congo, Ethiopia, Malawi, Mali, Niger, Pakistan, Rwanda and Uganda included modules on obstetric fistula in their Demographic and Health Surveys. Modules varied between countries, but contained questions regarding obstetric fistula knowledge and experience of obstetric fistula symptoms. In Ethiopia, one out of

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[21] World Health Organization and United Nations Population Fund, *National-level monitoring of the achievement of universal access to reproductive health: conceptual and practical considerations and related indicators* (Geneva: World Health Organization, 2007).

[22] *Maternal Mortality in 2005*, op. cit.

[23] The probability that a 15-year-old female will eventually die from a maternal cause.

[24] Velez et al., op. cit.

[25] *Guidelines for Monitoring the Availability and Use of Obstetric Services*, op. cit.

four women had heard of obstetric fistula. Of those who had, approximately 1 per cent who had ever given birth reported experiencing obstetric fistula symptoms.[26] In Mali, 16 per cent of women had knowledge of obstetric fistula and 0.2 per cent of women who had ever given birth reported ever suffering from obstetric fistula.[27] A standard module has now been developed and will be used in forthcoming surveys, including in Burkina Faso and Kenya.

33. In response to gaps in comparable data, Johns Hopkins University, UNFPA and WHO launched a research study in April 2008 entitled "Prognosis, improvements in quality of life (QOL) and social integration of women with obstetric fistula after surgical treatments". The research will be conducted over two years with partners in seven countries: Bangladesh, Benin, Ethiopia, Mali, Niger, Nigeria and the Sudan. The study aims to measure outcomes of treatment, including physical health and quality of life, with follow-up for one year after treatment.

B. Prevention strategies and interventions

34. Obstetric fistula can be prevented as part of efforts towards achieving goal 5, specifically through universal access to high quality and accessible reproductive health services, with emphasis on those with immediate impact potential: family planning, skilled birth attendance and emergency obstetric care. Lessons can be learned from countries that have successfully reduced maternal mortality and morbidity in relatively short time periods through national political and financial commitment and effective planning, such as Egypt, Honduras, Malaysia, Nicaragua, Sri Lanka and Thailand.

35. To address gaps in maternal care, numerous Governments, with support from United Nations agencies and others, are implementing plans to ensure robust, functioning health systems that provide a full continuum of maternal health care. Malawi, for instance, has finalized, costed and mobilized resources for its National Roadmap for Reducing Maternal and Newborn Mortality and Morbidity and has begun implementation of the operational plan. The plan aims to address staff shortages, limited availability and utilization of maternal health services, weak referral systems and inadequate community participation within a broader health systems approach. Numerous other countries are now mobilizing resources and beginning implementation of their road maps with support from the United Nations and bilateral donors. In Latin America, several partners[28] have organized training courses for representatives from countries in the region on health systems development, utilizing maternal health as a cross-cutting issue to analyse dimensions of health systems.

36. Access to family planning ensures that every pregnancy is wanted and can help to improve maternal and newborn health by ensuring optimal timing, spacing and number of births. Funding and priority for family planning has drastically declined in recent years. Efforts are under way to revitalize family planning efforts, including

[26] Central Statistical Agency, Addis Ababa and ORC Macro, Maryland, United States of America, *Ethiopia Demographic and Health Survey 2005*.

[27] Salif Samaké et al., *Mali: Enquête Démographique et de Santé (EDSM-IV) 2006*.

[28] The Pan American Health Organization (PAHO/WHO), UNFPA, the Swedish International Development Cooperation Agency (SIDA) and the Centro de Investigaciones y Estudios de la Salud (CIES) of Nicaragua.

mobilizing political and financial support. Through programmes in 140 countries, UNFPA works with Governments to ensure that information and a range of family planning methods is offered in all health facilities. In Madagascar, the President brought together faith-based groups, youth leaders, provincial health officers and ministers to underscore the cross-sectoral importance of population dynamics. Yemen has similarly prioritized family planning as a key strategy for improving health and development. WHO, UNFPA, the United States Agency for International Development (USAID) and other partners have recently produced new guidance for health professionals on providing quality family planning services.[29]

37. Member States have embarked on initiatives to increase access to prenatal, delivery and post-natal services, including emergency obstetric care. This includes strengthening health infrastructure with equipment, renovation and reliable supply systems. In addition it requires addressing human resource shortages. One key approach has been to increase the number and enhance the competencies of skilled birth attendants, particularly midwives. Midwives have been fundamental to reducing maternal and neonatal mortality and morbidity in many countries, such as Tunisia and Sri Lanka. In Cambodia, the findings of a comprehensive midwifery review were part of the midterm review of the health sector strategic plan. In Bolivia, the university and the Ministry of Education have endorsed a midwifery diploma programme. The Sudan aims to ensure that at least one midwife is posted to every village and recently revised its midwifery training curriculum to improve the competencies of newly trained midwives. Some developing countries have recently embarked on performance-based contract schemes to motivate health personnel to improve their performance. The experience from Rwanda shows that health facilities that had performance contracts have produced more and better services with lesser expenditure. To support efforts of Member States, UNFPA, WHO and the International Confederation of Midwives are working together to provide guidance for scaling up access to midwifery services.

38. Typical obstacles to accessing care include lack of transportation, large distances and high costs. Senegal recently implemented a policy to reduce socio-economic barriers to maternal health services by making deliveries and Caesarean sections free to reduce financial barriers, and delegating authority to provide emergency obstetric care closer to communities. A number of countries and agencies are also looking at means to promote community-based responses for emergency transport as well as increased collaboration between the health and transport sectors.

39. Many countries recognize the need to find additional ways to finance health services while still supporting the poor and vulnerable. The Honduras Family Allowance Programme includes provision of a voucher to pregnant and lactating mothers and to children under 3 years as a way to improve their health and nutrition.[30] Conditional cash transfers which provide monetary resources to households on condition that they follow specific requirements are now being implemented in Latin America, Africa and Asia with some degree of success.[31]

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[29] *Family Planning: A Global Handbook for Providers*, 2007.

[30] C. Moore, *Assessing Honduras' CCT Programme PRAF, Programa De Asignacion Familiar: Expected and Unexpected Realities*, International Poverty Centre, Country Study No. 15, April 2008.

[31] M. Lagrande, A. Haines and N. Palmer, "Conditional cash transfers for improving uptake of health interventions in low- and middle-income Countries: a systematic review", *JAMA*, vol. 298, No. 16 (24-31 October 2007), pp. 1900-1910.

Social health insurance is being implemented in a number of countries, including most recently Rwanda and Ghana.

40. Effective responses to maternal death and disability consider also the social and cultural determinants. Behaviour change interventions and community mobilization raise awareness and understanding at the community level. A pilot community mobilization project in Eritrea implemented by the Government and supported by UNFPA demonstrated that mobilization of community leaders and training of male and female health educators in safe motherhood can contribute to increased utilization of services. In northern Nigeria, male and female community educators, some of whom are survivors of obstetric fistula, have been trained in maternal health, including prevention of obstetric fistula, as part of a promising pilot supported by UNFPA and Virgin Unite. In a short time, they have reached hundreds of gatekeepers, men and pregnant women, resulting in increased utilization of maternal health services. UNICEF has developed a home-based care training package for community health workers which focuses on birth preparedness during pregnancy, including motivation to deliver with a skilled attendant, awareness-raising on danger signs and early care seeking, coupled with early post-natal visits. These programmes being implemented in some countries are linked with strengthening capacity of health facilities to provide emergency obstetric care.

41. Empowering women who have survived obstetric fistula and their families, for example through peer support groups and counselling, helps prevent a recurrence of obstetric fistula in future pregnancies. It also enables women who have lived with obstetric fistula to play a role in stimulating behaviour change to prevent new cases. A number of non-governmental organizations such as the International Association for Maternal and Neonatal Health (IAMANEH) in Mali engage obstetric fistula survivors as advocates, counsellors and community mobilizers to promote maternal health and girls' education.

42. Investing in education for girls and ending child marriage are critical to ending obstetric fistula and protecting and promoting the rights of the girl child. Girls who are marginalized are those who bear the highest risks of maternal deaths and disabilities, including obstetric fistula. Prevention efforts in some countries target these vulnerable adolescent girls, coupled with interventions that promote girls' education, increase the minimum age at marriage, and promote their access to health services and economic empowerment initiatives. Many countries are now establishing a legal minimum age for marriage, but often have difficulties enforcing the laws, thus requiring additional efforts to change socio-cultural practices. For example, the Government of Ethiopia, with support from UNFPA, launched a Stop Child Marriage campaign to raise awareness about the dangers/rights violations of this harmful practice and enforce the child marriage law. In Guatemala, UNFPA works with partners in supporting indigenous adolescent girls with livelihood skills and job opportunities, along with education in sexual and reproductive health.

C. Treatment and reintegration strategies and interventions

43. Although prevention is the ultimate means of ending obstetric fistula, treatment is still needed for women living with the condition. The average cost of treatment is approximately $300 per case. Member States have embarked on efforts to increase access to obstetric fistula treatment through the upgrading of health facilities and training of health personnel. UNFPA has provided support to more than 40 countries, resulting in treatment for more than 7,800 women and the training of over 500 health professionals since the global Campaign to End Fistula began.

44. Great strides have been made on the normative front with attempts to harmonize standards and to collect evidence-based data to inform national planning. With inputs from experts and the international Obstetric Fistula Working Group, WHO released a manual in 2006 that outlines guiding principles for developing national programmes on prevention of and provision of obstetric fistula treatment and care.[32]

45. Efforts in Ethiopia and Nigeria continue to remain at the forefront. The Addis Ababa Fistula Hospital in Ethiopia, the longest running and largest obstetric fistula treatment centre in the world, is expanding to five satellite centres across Ethiopia. This will enable the hospital to treat women closer to their communities and expand training in obstetric fistula management for health professionals from Ethiopia and other countries. Nigeria has numerous centres around the country and perhaps the largest number of experts in obstetric fistula surgery in the world. Health professionals from around the globe are trained in Babbar Ruga Fistula Hospital every year, and Nigerian doctors travel to other countries to assist in training and providing treatment.

46. Since the Campaign's launch, more than 20 countries have established at least one centre for obstetric fistula treatment. Building upon these national centres, many countries have begun decentralizing services to ensure greater access. In Bangladesh, a national centre of excellence is being established in Dhaka with treatment decentralized to nine regional medical college hospitals. A similar approach has been adopted in Kenya where four hospitals serve as referral centres for the surrounding districts and train district-level providers. The United Republic of Tanzania has developed a three-tiered system of referral for obstetric fistula treatment.

47. Outreach service campaigns also provide an important means of clearing the backlog of cases for treatment, bringing care closer to women and building the capacities of health providers in obstetric fistula treatment. UNFPA is currently field testing guidance on planning outreach treatment services.[33] Twenty-seven outreach service campaigns were organized in Pakistan in 2007 allowing the simultaneous training of health professionals. Similar training workshops were organized in Uganda in 2007 and support was also provided for outreach service campaigns at four sites. Outreach services have been particularly useful in conflict and post-conflict settings where routine services may be difficult to provide. In November 2007, UNFPA together with the staff of Hargeisa Group Hospital and the

[32] World Health Organization, *Obstetric Fistula: Guiding principles for clinical management and programme development*, 2006.

[33] Fistula outreach is conducted in a facility that does not offer regular fistula treatment services.

Ministry of Health launched the first obstetric fistula treatment outreach campaign in Somalia.

48. Obstetric fistula has severe social, economic and psychological consequences for affected women. To address this problem, UNFPA has partnered with civil society organizations to help women reintegrate in society and resume a full life free of stigma. Rehabilitation services focus on rebuilding the self-esteem of women, socio-economic empowerment through income-generating activities, microfunding schemes as well as literacy or vocational training and provision of counselling services to promote health-seeking behaviour to prevent recurrence of obstetric fistula. These organizations also engage in awareness-raising activities in the community to reduce misperceptions and stigma around childbirth complications.

49. Through a partnership between the Government, UNFPA and the Bangladesh Women's Health Coalition, Bangladeshi women seeking obstetric fistula treatment receive rehabilitation services including counselling and a training package on income-generating activities and functional education. Linkages with the National Fistula Treatment Centre ensure continuity of care. In addition, a component is aimed at raising community awareness and ensuring periodic visits to follow up with patients and counsel family members. In Niger, non-governmental organizations provide a package of economic empowerment, reproductive health services to prevent the recurrence of obstetric fistula and counselling and sensitization for family and community members.

D. Advocacy and awareness-raising

50. The needs assessments conducted across countries highlighted the lack of awareness and neglect of the condition making concentrated efforts to advocate and raise awareness imperative. Advocacy efforts have targeted a variety of audiences in both donor and developing countries, including policymakers, health professionals, media and the public. Significant interest has arisen from donor Governments, national and international non-governmental organizations and the private sector. Well-known personalities have become engaged in raising awareness, including Heads of State, First Ladies and celebrities. Increasingly, UNFPA has been supporting the participation of women who have lived with obstetric fistula in advocacy to convince communities and policymakers of the right to treatment and the importance of preventing maternal death and disability.

51. The integration of obstetric fistula into national policies is key to securing political and financial commitment. In many countries, the fight against obstetric fistula has over the last few years been integrated in reproductive and maternal health national agendas. Sixteen countries have now integrated obstetric fistula in relevant national health plans and strategies.[34]

52. Media are being utilized to reach many audiences. Key partnerships have been formed with the media in Ghana through the national Media Communication and Advocacy Network. Radio serves as an important means to reach populations most affected and has been utilized in Côte d'Ivoire, Ghana, Liberia, Nigeria, Pakistan

[34] Afghanistan, Bangladesh, Benin, Cameroon, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Liberia, Malawi, Mali, Mauritania, Niger, Pakistan and Senegal.

and the Sudan, to raise awareness on maternal health and obstetric fistula and to inform women living with obstetric fistula about available treatment and care.

E. Global support and resource mobilization

53. Significant global momentum now exists to address maternal health within the context of the Millennium Development Goals. The events tied to the twentieth anniversary of the Safe Motherhood initiative in 2007 helped to rally support for goal 5. In addition, several global initiatives are under way to support achievement of the health Millennium Development Goals, some formed as lobbying groups of international health organizations for high-level political advocacy, others as alliances of international non-governmental organizations and United Nations agencies to coordinate interventions.

54. Since 2003, the global Campaign to End Fistula has grown from 12 countries to more than 45 African, Asian, and Arab States. More than $50 million[35] in contributions have been leveraged in the last five years to support obstetric fistula activities by partners in the Campaign from Governments, international financial institutions and the private sector, including individual donors. At the global level, the international Obstetric Fistula Working Group promotes global coordination of efforts and plans joint initiatives. The Group, coordinated by UNFPA, includes United Nations agencies, international and regional non-governmental organizations, academic institutions, professional associations, faith-based organizations and health facilities. The Group strives to ensure that obstetric fistula is situated within maternal mortality and morbidity reduction and to generate consensus and evidence on effective strategies for the treatment and reintegration of women living with obstetric fistula.

55. The Partnership for Maternal, Newborn and Child Health, a global health partnership launched in September 2005 which joined maternal, newborn and child health communities into an alliance of some 240 members, continues to grow. The Partnership brings these actors together to make the development case for maternal, newborn and child health and raise visibility and support for these issues. The members work together to align and accelerate activities, develop cohesive messages and share knowledge on effective approaches.

56. Leaders of eight international agencies active in health[36] have formed an informal group aimed at better coordinating support to countries. The group recognizes the need to strengthen health systems and to support one national process in the health sector. Within this framework, the International Health Partnership, launched in September 2007, is an agreement between donor and developing countries, international health agencies including the United Nations, and foundations to improve collaboration, and emphasizes national priorities identified in national health plans. Eight countries in Africa and Asia[37] have joined and more

[35] The figure is based on contributions received for the largest programmes and does not account for all funding.

[36] The United Nations Population Fund, the United Nations Children's Fund, the Joint United Nations Programme on HIV/AIDS, the World Health Organization, the World Bank, the Bill and Melinda Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance Health System Strengthening.

[37] Burundi, Cambodia, Ethiopia, Kenya, Mali, Mozambique, Nepal and Zambia.

countries have expressed interest. The Global Health Workforce Alliance is dedicated to identifying and implementing solutions to the health workforce crisis. Hosted by WHO, it brings together national Governments, civil society, finance institutions, health workers, international agencies, academic institutions and professional associations to address the call for urgent and coordinated action on the health workforce crisis, including midwifery.

57. UNICEF, UNFPA, WHO and the World Bank have agreed to better coordinate their support to countries to improve maternal and newborn health. Coordination is guided by a continuum of care and support to one national health plan, drawing on each agency's strengths, assigning key responsibilities for each agency and promoting effective mechanisms for country-level coordination.

58. An Inter-Agency Task Force on Adolescent Girls[38] was established in 2007 under the leadership of UNFPA to support Governments to invest in adolescent girls as a strategy for poverty reduction, prevention of child marriage, reducing maternal mortality and morbidity and the promotion of adolescent health, including sexual and reproductive health. The overall purpose of the Task Force is to strengthen inter-agency collaboration at both global and country levels for more effective programmes targeting adolescent girls.

59. In January 2008 UNFPA established the Thematic Fund for Maternal Health. The Fund seeks to mobilize $500 million over four years to support the 60 countries with the highest maternal mortality. The goal of this initiative is to increase the capacity of health systems to provide a continuum of quality maternal health care, strengthen mechanisms to reduce health inequities and empower communities to exercise their rights to reproductive health.

60. The Countdown to the 2015 Conference held in South Africa in April 2008 drew attention to the challenges of achieving Millennium Development Goals 4 and 5 in 68 priority countries with high maternal and under 5 mortality, culminating with a Statement of Commitment from policymakers, pledging actions towards improving maternal and child health. At the July 2008 Group of Eight (G8) meeting in Japan, the United Nations emphasized the need for a global push to address maternal health. The G8 leaders in their statement on Development in Africa noted that goals 4 and 5 are seriously off-track in some countries and urged greater focus on maternal, newborn and child health and access to reproductive health.

V. Conclusions and recommendations

61. **Considerable progress has been achieved over the last two decades in focusing attention on maternal death and disability, and more recently specifically on obstetric fistula. This has mainly been due to greater evidence on effective interventions, enhanced data collection and analysis, advocacy programmes, partnerships, and subsequently stronger political and financial commitments. There is now greater understanding of the social and economic**

[38] Department of Economic and Social Affairs of the Secretariat, United Nations Population Fund, United Nations Children's Fund, Office of the United Nations High Commissioner for Refugees, United Nations Fund for International Partnerships, Joint United Nations Programme on HIV/AIDS (UNAIDS), International Labour Organization, United Nations Educational, Scientific and Cultural Organization and World Health Organization.

burden that results from poor reproductive and maternal health, its relation to poverty reduction and consensus on key interventions to reduce maternal death and disability. Awareness and recognition of the problem of obstetric fistula have grown exponentially. Countries are increasingly investing in and promoting the prevention, treatment and reintegration of women living with obstetric fistula as part of efforts to improve maternal health.

62. **In addition, multisectoral approaches have been undertaken in many places to draw linkages between poverty, income inequalities, gender disparities, discrimination and poor education, as these contribute to the poor health of women and girls. Efforts include education of women and girls, economic empowerment, including access to microcredit and microfinance, and legal reforms and social initiatives to delay marriage and pregnancy.**

63. **Despite these positive developments, serious challenges remain. The struggle to improve health systems and reduce maternal mortality and morbidity, including obstetric fistula, must not only continue but intensify. There is an urgent need to scale up interventions to prevent the more than 500,000 deaths and 9 million morbidities[39] that occur annually due to complications of pregnancy and childbirth. In addition, women living with obstetric fistula need treatment and reintegration services. The global strategy to achieve this will include, among other things, stronger links between policy formulation and policy implementation in the health sector, increased share of national budget allocations, higher investment in health systems in particular for maternal health, partnerships at the national level between civil society and communities as well as increased cooperation at the global level with financial institutions and other relevant actors.**

64. **Specific actions required to be taken to improve maternal health and to address the issue of obstetric fistula include:**

(a) **Greater investments in health systems, emphasizing human resources, to improve health services and ensure that women and girls have access to the full continuum of reproductive health care, in particular family planning, skilled delivery care and emergency obstetric care. The continuum should cover the period from adolescence through pre-pregnancy, pregnancy, childbirth and the post-natal period;**

(b) **Efforts focused on supporting national plans to strengthen health systems and to access and address the underlying social, cultural and economic determinants of maternal death and disability. Special attention should be paid to areas with the highest maternal mortality and morbidity, particularly in sub-Saharan Africa and South Asia. Within countries, approaches must strive to reach the poor, rural populations and adolescent girls;**

(c) **Investments to support national health plans and address health-care coverage inequalities among socio-economic and age groups, in particular in rural areas. Priorities must include access to a range of contraceptive methods in health facilities and other channels, human resource plans for health workers, especially midwives, and appropriate investments in infrastructure, equipment and supply chains to ensure provision of emergency obstetric care.**

[39] United Nations Statistics Division, Progress towards the MDGs 1990-2005: goal 5, June 2005.

These need to be linked to other health issues that contribute to high maternal mortality and morbidity, such as poor nutrition, HIV and AIDS prevention and malaria control;

(d) At least one referral service or centre for obstetric fistula treatment established in each country with high prevalence, and where possible services should be decentralized to bring care closer to women. Other mechanisms, such as outreach service campaigns, should be utilized until this care can be provided routinely to help reduce the backlog of women awaiting treatment. Additionally, linkages with civil society organizations and women's empowerment programmes should be developed to ensure access to social reintegration support, including counselling, literacy and health education, skills development and income-generating activities;

(e) Making maternal health services and obstetric fistula treatment geographically and financially accessible and culturally acceptable. Geographic access requires adequate distribution of health facilities and personnel, collaboration with the transport sector to ensure affordable transport options and promotion of community-based solutions. Financial access requires innovative mechanisms to ensure that delivery care and obstetric fistula treatment are free or highly subsidized for women who cannot afford it. Service delivery should take into account the cultural preferences of the population;

(f) The mobilization of communities so that they are involved, informed and empowered about maternal health needs, utilize services and support women in accessing services. Civil society organizations can play a role in working with communities. Women who have lived with obstetric fistula can also be empowered to contribute to these efforts, as survivors of obstetric complications. Men and boys particularly need to be engaged to advocate for services and support women to access these services;

(g) Strengthened and expanded interventions to keep adolescent girls in school, stop child marriages, and promote gender equality and positive health-seeking behaviours. Laws against child marriage need to be enforced, followed by innovative incentives for families to delay marriage. Programmes for adolescent girls providing comprehensive life skills, including reproductive health information, need to reach the populations at greatest risk of child marriage and adolescent pregnancy. Reproductive health education programmes in schools need to be maintained to ensure that young people have the information and skills to protect their own health;

(h) Stronger research, monitoring and evaluation to guide implementation of maternal health programmes. Countries should have monitoring and evaluation systems, including community-based notification of obstetric fistula cases and maternal and newborn deaths. Research addressing determinants and consequences of maternal death and disability needs support, including the quality of life consequences of maternal morbidities such as obstetric fistula;

(i) Partnerships and coordination of efforts maintained between a variety of stakeholders at the local, national, regional and global levels to address the multifaceted determinants of maternal mortality and morbidity.

65. **The challenge to end obstetric fistula requires intensified efforts at the national, regional and international levels. These efforts must be part of strengthening health systems to achieve Millennium Development Goal 5. If goal 5 is to be achieved, additional resources must be forthcoming. To support priority countries, at least $1.2 billion per year for family planning and $6 billion annually for maternal health care are required, including for prevention of obstetric fistula. An estimated $750 million would be needed to treat existing and new cases of obstetric fistula between now and 2015, assuming the decline of new cases each year. The funding needs to be predictable and sustained. Continued support should be provided to countries' national plans, United Nations entities including the global Campaign to End Fistula, and the Thematic Fund for Maternal Health, and other global initiatives, dedicated to achieving Millennium Development Goal 5.**